New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration

ATTACHMENT C: DSRIP PLANNING PROTOCOL

I. Preface

a. Delivery System Reform Incentive Payment Fund

On January 5, 2016, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's request for expenditure authority to operate its section 1115(a) Medicaid demonstration (hereinafter "demonstration") entitled *Building Capacity for Transformation*, a Delivery System Reform Incentive Payment (DSRIP) program. Under the DSRIP demonstration program, the state will make performance-based funding available to regionally-based Integrated Delivery Networks (IDNs) that serve Medicaid beneficiaries, with the goal of transforming New Hampshire's behavioral health delivery system by strengthening community-based mental health and substance use services and combatting the opioid crisis. The demonstration is currently approved through December 31, 2020.

The Special Terms and Conditions (STCs) of the waiver set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period.

b. DSRIP Planning Protocol

The requirements specified in the STCs are supplemented by the Quarterly Report Format (Attachment A), the DSHP Claiming Protocol (Attachment B), the DSRIP Planning Protocol (Attachment C), and the DSRIP Program Funding and Mechanics Protocol (Attachment D).

In accordance with STC 26, the DSRIP Planning Protocol (this attachment, Attachment C) describes the context, goals and objectives of the waiver in Section II; identifies a menu of delivery system improvement projects in Section III; specifies a set of project stages, milestones and metrics to be reported by IDNs in Section IV; details the requirements of the IDN Project Plans in Section V; and specifies a process to allow for potential IDN project plan modification in Section VI.

This version of the DSRIP Planning Protocol is approved as of [DATE]. In accordance with STC 26, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

c. Supporting Project and Metrics Specification Guide

This attachment will be supplemented by a Project and Metrics Specification Guide developed by the state and approved by CMS. This Guide will assist IDNs in developing and implementing their projects and will be used in the state's review of the IDN Project Plans, described in Section V below. The Project and Metrics Specification Guide will also provide additional information on the stages, milestones and metrics described in Section IV below, including the data source for each measure, the measure steward for each metric (if applicable), and the methodology used to establish outcome goals and improvement targets, as described in the Program Funding and Mechanics Protocol (Attachment D).

II. Context, Goals and Objectives

a. New Hampshire Context

New Hampshire's *Building Capacity for Transformation* Section 1115 Demonstration Waiver aims to transform the way care is delivered to some of the most medically complex and costly Medicaid beneficiaries in the state as well as to individuals with undiagnosed or untreated behavioral health conditions. A number of factors make behavioral health transformation a priority of the state including the expansion of coverage through the New Hampshire Health Protection Program (NHHPP) to cover the new adult group, an estimated one in six of whom have extensive mental health or substance use needs. In addition, New Hampshire now covers substance use disorder (SUD) services for the NHHPP population, and the state is targeting g extension of the SUD benefit to the entire Medicaid population in state fiscal year 2017. Finally, the expansion of coverage for new populations and new services coincides with an epidemic of opioid abuse in the state and across New England.

The demand for mental health and substance abuse services is increasing, and the existing capacity is not well-positioned to deliver the comprehensive and integrated care that can most effectively address the needs of patients with behavioral health conditions or comorbid physical and behavioral health diagnoses. This demonstration responds to this pressing need to transform New Hampshire's behavioral health delivery system.

Under the demonstration, diverse sets of health and social service providers within regions across the state will create IDNs capable of implementing evidence-supported programs that address the needs of Medicaid beneficiaries with behavioral health conditions. The principle elements of these programs will include:

- Integrating physical and behavioral health to better address the full range of beneficiaries' needs;
- Expanding mental health and substance use disorder treatment capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions across care settings through improved coordination for individuals with behavioral health conditions.

The population to be addressed by the demonstration includes Medicaid beneficiaries of all ages with, or at risk for, behavioral health conditions ranging from moderate depression and anxiety to substance use, to serious mental illness. While some of these conditions respond well to prevention strategies, early intervention and a short term course of treatment, others are serious chronic illnesses that require a long term recovery process often resulting in ongoing treatment and management.

b. Demonstration Goals and Objectives

The demonstration is aimed at achieving the following goals:

- Improve the health and well-being of Medicaid beneficiaries and other New Hampshire residents with behavioral health conditions through the implementation of evidence-supported programs coupled with access to appropriate community-based social support services to improve physical and behavioral health outcomes.

- Improve access to behavioral health care throughout all of NH's regions by:
    - Increasing community-based behavioral health service capacity through the education, recruitment and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of substance use and mental health services,
    - Establishing robust technology solutions to support care planning and management and information sharing among providers and community based social support service agencies, and
    - Incentivizing the provision of high-need services, such as medication-assisted treatment for substance use disorders, peer support and recovery services.

- Foster the creation of IDNs that are built upon collaboration among partners including Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), SUD clinics (including recovery providers), hospitals, independent primary care providers (PCPs), psychiatrists, psychologists and other behaviorists, medical specialists, county organizations such as nursing facilities and sheriffs), peer and family support counselors, and community-based social support agencies that serve the target

population in a region or regions. As described in detail in the Program Funding and Mechanics Protocol (Attachment D), IDNs must ensure they have a network of both medical and non-medical providers that together represent the full spectrum of care and related social services that might be needed by an individual with a mental health or substance use disorder in their geographic region (e.g., housing, food access, income support, transportation, employment services, and legal assistance).

- Reduce the rate of growth in the total cost care for Medicaid beneficiaries with behavioral health conditions by reducing avoidable admissions and readmissions for psychiatric and physical diagnoses and avoidable use of the Emergency Department (ED) through more effective use of community-based options.

To achieve these goals the IDNs will be charged with selecting and implementing specific evidence-supported projects and participating in statewide planning efforts. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings. In addition the IDNs will engage in a phased transition to Alternative Payment Models (APMs). These four elements are embedded in the following demonstration objectives:

1. Increase the state's capacity to implement effective community based behavioral health prevention, treatment and recovery models that will reduce unnecessary use of inpatient and ED services, hospital readmissions, the cycling of justice-involved individuals between jail and the community due to untreated behavioral health conditions, and wait times for services.

2. Promote integration of physical and behavioral health providers in a manner that breaks down silos of care among primary care, SUD and mental health providers. The level of integration to be achieved will be based on existing standards being developed through the State Innovation Model (SIM) planning process and the SAMHSA-defined standards for *Levels of Integrated Healthcare*.

3. Enable coordinated care transitions for all members of the target population regardless of care setting (e.g. CMHC, primary care, inpatient hospital, corrections facility, SUD clinic, crisis stabilization unit). The objective is to ensure that the intensity level and duration of transition services are fully aligned with an individual's documented care plan, which will be based on an up-to-date, standard core comprehensive assessment.

4. Ensure IDNs participate in Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

To achieve these objectives, each IDN will be required to build a care continuum with the capacity to meet the needs of Medicaid beneficiaries with behavioral health conditions (diagnosed and undiagnosed) and to implement projects to further the objectives and goals of the demonstration. Additional details on the projects that IDNs are expected to implement and related metrics are provided in Sections III and IV.

III. Project Protocols Menu

a. Overview of Project Categories

Each IDN will be required to implement six projects to address the needs of Medicaid beneficiaries with diagnosed and undiagnosed behavioral health conditions within the population it serves. These six projects will be spread across the following three categories:

- Statewide Projects (2 mandatory projects for all IDNs)
- Core Competency Project (1 mandatory project for all IDNs); and
- Community Driven Projects (IDNs select 3 projects among options)

For each project, the IDN will develop detailed plans and focused milestones as part of the IDN's Project Plan. As described in Section IV, project performance will be measured based on milestones and metrics that track: project planning/implementation progress; clinical quality and utilization indicators; and progress towards transition to Alternative Payment Models.

b. Description of Project Categories

1. Statewide Projects (Mandatory for all IDNs)

Each IDN will be required to implement two Statewide Projects that are designed to address the following critical elements of New Hampshire's vision for transformation: (1) a workforce that is equipped to provide high-quality, integrated care throughout the state and, (2) an HIT infrastructure that allows for the exchange of information among providers and supports a robust care management approach for beneficiaries with behavioral health conditions.

IDNs will be required to implement the following two Statewide Projects:

- **A1. Behavioral Health Work Force Capacity Development**
- **A2. Health Information Technology Planning and Development**

The effectiveness of these projects is dependent on active coordination across IDNs, and as such they will be supported by a state-wide planning effort that includes representatives from across New Hampshire. All IDNs will be required to participate in each of these projects through their respective collaborative statewide work groups with members drawn from across the mental health and substance use provider communities in each IDN, as well as those with expertise in HIT and other members who can bring relevant experience and knowledge. These work groups will be charged with identifying the workforce capacity and technology requirements to meet demonstration goals and with assessing the current gaps across the state and IDN regions. Using the work groups' findings, the IDNs will be required to develop regional approaches to closing the work force and technology gaps that impact the capacity for coordinated care management and information sharing; among medical, behavioral and social service providers. The work groups will assess the current state and develop a future state vision that incorporates strategies to efficiently implement statewide or regional technology and workforce solutions. IDNs must participate in these projects and fulfill state-specified requirements in order to be eligible for performance funding.

2. **Core Competency Project (Mandatory for all IDNs)**

Each IDN will be required to implement one Core Competency Project to ensure that behavioral health conditions are routinely and systematically addressed in the primary care setting and vice versa. Foundational to transformation efforts, IDNs are required to integrate mental health and substance use disorder services and primary care through the following Core Competency project:

- **B1. Integrated behavioral health and primary care**

  Primary care providers, behavioral health providers, and social services organizations will partner to implement an integrated care model that reflects the highest possible levels of collaboration/integration as defined within the SAMHSA Levels of Integrated Healthcare. The model will enable providers to collaborate to prevent and quickly detect, diagnose, treat and manage behavioral and medical conditions using standards of care that include:

  - Core standardized assessment framework that includes evidence based universal screening for depression and SBIRT
  - Health promotion and self-management support
  - Integrated electronic medical record

- Multi-disciplinary care teams that provide care management, care coordination and care transition support
- An electronic assessment, care planning and management tool that enables information sharing among providers

IDNs must participate in this project and fulfill state-specified requirements in order to be eligible for DSRIP incentive payments. Given the foundational nature of the project, IDNs are required to complete the process requirements for the project by no later than December 31, 2018.

3. **Community Driven Projects (IDNs can select among options).**

Each IDN is required to select a total of three community-driven projects from a Project Menu established by the state. The IDN Project Menu is broken down into three categories, and IDNs will select one project within each of the following categories: (1) Care Transition Projects designed to support beneficiaries with transitions from institutional settings into the community; (2) Capacity Building Projects designed to strengthen and expand workforce and program options; and (3) Integration Projects designed to integrate care for individuals with behavioral health conditions among primary care, behavioral health care and social service providers.

The IDN Community Driven Menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through a behavioral health needs assessment and community engagement. IDNs will be required to conduct a behavioral needs assessment as part of development of the IDN Project Plans described further in Section V. The menu of community-driven projects gives IDNs the flexibility to target key sub-populations; to change the way that care is provided in a variety of care delivery settings and at various stages of treatment and recovery for sub-populations; and to use a variety of approaches to change the way care is delivered. The goal is to employ these services across the state to ensure a full spectrum of care is accessible for individuals with active diagnoses and those who are undiagnosed or at risk.

1. **Care Transitions Projects:** Support beneficiaries with transitions from institutional setting to community
    - **C1. Care Transition Teams**
    - **C2. Community Reentry Program for Justice-Involved Individuals**
    - **C3. Nursing Home Transitions of Care**
    - **C4. Supportive Housing**

2. **Capacity Building Projects:** Expand availability and accessibility of evidence supported programs across the state and supplement existing workforce with additional staff and training
    - **D1. Medication Assisted Therapy (MAT)**
    - **D2. Mental Health First Aid for Medical Providers, Law Enforcement, and Social Services Providers**
    - **D3. Treatment Alternatives to Incarceration (CIT)**
    - **D4. Parachute Program for the Unserved**
    - **D5. Zero Suicide**
    - **D6. Community-Based Stabilization**
    - **D7. Coordinated Specialty Care for First Episode Psychosis**
    - **D8. Peer Support for Full Range of Behavioral Health Services/Community Health Worker Program**

3. **Integration Projects***:* Promote collaboration between primary care and behavioral health care
    - **E1. InSHAPE Program**
    - **E2. School-Based Screening and Intervention**
    - **E3. Treatment Alternatives to Incarceration (Universal Screening)**
    - **E4. Early Childhood Prevention and Interventions**
    - **E5. Collaborative Care/IMPACT Model**
    - **E6. Integrated Dual Disorder Treatment**
    - **E7 Enhanced Care Coordination for High Risk/High Utilization- Multiple Chronic Condition Populations**

Table 1. Project Protocols Menu

#	PROJECT	DESCRIPTION
A. STATE-WIDE PROJECTS		*IDNs required to implement both projects*
A1	**BH Workforce Capacity Development**	Cross-IDN, statewide, workforce capacity planning, including: (1) gap analysis of professionals, allied professionals and peers; (2) regional workforce capacity targets; (3) training curricula; and (4) pipeline improvement plans. IDNs to use statewide planning work products to develop and implement IDN project.
A2	**Health Information Technology Planning and Development**	IDNs to participate in statewide HIT/E planning to: (1) develop requirements for electronic coordinated care management system and information sharing; (2) assess current state of technology use in care planning, management and tracking; (3) consider strategies to efficiently implement statewide or regional technology solutions; and (4) develop milestones for IDNs to demonstrate steps towards having a technology platform to share care coordination data across all IDN providers inclusive of social service providers..
B. CORE COMPETENCY PROJECTS		*IDNs required to implement this project*

#	PROJECT	DESCRIPTION
B1	**Integrated Behavioral Health and Primary Care**	Pediatric and adult behavioral health and primary care providers, working in concert with social services organizations, will implement a collaborative, integrated care model that reflects the highest feasible levels of collaboration/integration as defined within the SAHMSA Levels of Integrated Healthcare (e.g., Level 5 or 6). Primary care providers, behavioral health providers, and social services organizations will partner to: • Provide prevention, detection, accurate diagnosis, treatment, and follow-up of both behavioral health and physical conditions, and referral to community and social support services • Address health behaviors (including those contributing to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization Standards will include: • Use of a core standardized assessment framework, including universal evidence-supported screening for depression, substance use (e.g., PHQ2 & 9, SBIRT), and medical conditions , and a patient activation tool/measure (e.g., Patient Activation Measure, or PAM) • Integrated electronic medical records • Health promotion and self-management support • Use of multi-disciplinary care teams that provide care to the whole person through a 'no wrong door' model of care management and care coordination services including comprehensive transitional care from inpatient to other settings, patient monitoring and follow-up support services • An electronic care planning/tracking tool that can be shared among a patient's provider team inclusive of social support service providers
C. COMMUNITY-DRIVEN PROJECTS		*IDNs to select one project from the Care Transitions, Capacity Building, and Integration Categories*
C. Care Transitions		*IDNs to select one project from this category*
C1	**Care Transition Teams)**	Time limited care transition program with multi-disciplinary team that follows 'Critical Time Intervention' approach to provide care at staged levels of intensity to support SMI patients with transitions from an institutional setting back to the community.
C2	**Community Reentry Program for Justice-Involved Individuals**	Community reentry planning: a time-limited program for justice-involved populations transitioning back into the community including supports for substance use disorder, co-occurring disorders, and mental health service coordination with Department of Corrections Probation and Parole
C3	**Nursing Home Transitions of Care**	Early intervention by multi-disciplinary team identifies, assesses, treats and manages care for residents with behavioral health conditions using consulting psychiatrist to prevent unnecessary inpatient admissions, and provide smooth care transitions as necessary.
C4	**Supportive Housing**	IDNs will partner with community housing providers to develop transitional and/ or permanent supportive housing for high risk patients who, due to their physical or behavioral condition, have difficulty transitioning safely to the community or are in need of short term interventions to safely transition to the community.
D. Capacity Building		*IDNs to select one project from this category*
D1	**Medication Assisted Therapy (MAT)**	Implement evidence based program combining behavioral therapy and medications to treat SUD.

#	PROJECT	DESCRIPTION
D2	**Mental Health First Aid for Medical Providers, Law Enforcement, and Social Services Providers**	Adult public education program to train adults to assist individuals with mental health and SUD who are in crises through ALGEE process: Assess, Listen, Give reassurance, Encourage professional help; Encourage self-help;
D3	**Treatment Alternatives to Incarceration (Crisis Intervention Team)**	The Crisis Intervention Team (CIT) model provides police officers 40 hours of training provided by mental health clinicians, consumer and family advocates, and police trainers. Training includes: information on signs and symptoms of mental illnesses; mental health treatment; co-occurring disorders; legal issues; and de-escalation techniques. Information is presented in didactic, experiential and practical skills/scenario based training formats.
D4	**"Parachute Program"**	A comprehensive crisis response program centered around 24/7 Crisis Respite Centers that offer an alternative to hospitalization for people experiencing emotional crises, and are largely staffed by trained peers who themselves have had their own experiences with the mental health system. Mobile crisis teams are an important component of the model. This program will be expanded to underserved regions under the Demonstration to ensure accessibility to populations not currently served.
D5	**Zero Suicide**	Zero Suicide is a systemic approach that aims to improve quality through use of evidence based practices directed at suicide prevention. It aims to close gaps in care, provide training to systematically identify and assess suicide risk among people receiving care.
D6	**Community-Based Stabilization**	Community based medication assisted treatment withdrawal management and harm reduction service programs paired with mental health services for individuals with substance use disorders that are linked to treatment and care management services.
D7	**Coordinated Specialty Care for First Episode Psychosis**	Multi- disciplinary team with small client to staff ratio intervenes with individuals during or shortly after their first psychotic episode. The program is intense and time limited (2-3 years) using multi-disciplinary team members including peers and provides family support services.
D8	**Peer Support for Full Range of Behavioral Health Services/Community Health Worker Program**	Counselor with lived experience with mental health or substance use conditions and who is trained in the provision of peer recovery support services assists clients with recovery by recognizing and developing strengths, and setting goals.
E. Integration		*IDNs to select one project from this category*
E1	**InSHAPE Program**	Wellness program that brings together community organizations concerned with health, exercise and nutrition to provide participants with health mentors, fitness activities, nutrition counseling, smoking cessation support, medical support, etc.
E2	**School-based Screening/Intervention**	IDN-wide program planning for school based mental health and substance use screening and brief intervention. School based staff trained to identify at risk students and to handle low severity mental health and risky substance use. Development of referral to treatment protocols required.
E3	**Treatment Alternatives to Incarceration (Universal Screening)**	Evidence based depression and substance use screening and treatment for Medicaid eligible individuals entering the justice system with post-discharge follow up services through community re-entry program.
E4	**Early Childhood Prevention and Interventions**	Promote the wellness of young children ages birth to 8 by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Prevention and intervention includes: improved screening activities; mental health consultation to early child care settings; promotion of family support; parent education; and evidence-based home visiting to support optimal social-emotional wellness.

#	PROJECT	DESCRIPTION
E5	**Collaborative Care/IMPACT Model**	Implement evidence-based depression care model based in primary care practices using depression care manager and consulting psychiatrist to support PCP in treatment of patients with mild to moderate depression and anxiety.
E6	**Integrated Dual Disorder Treatment (IDDT)**	An evidence based multi-disciplinary program combining SUD treatment and mental health treatment using 'stages of change/treatment' approach along with pharmacological and psychosocial therapies and holistic program supports
E7	**Enhanced Care Coordination for High Risk/High Utilizing Populations/Multiple Chronic Condition Populations**	Comprehensive care management services for high need populations including opioid addicted individuals, those with co-occurring intellectual disability and mental health conditions, and other identified high utilizing individuals with multiple chronic conditions and/or social factors that are barriers to improved well-being.

IV. Project Stages, Milestones, and Metrics

a. Stage :1 Capacity Building Elements Description, Progress Milestones, and Metrics

During DSRIP Year 1, IDNs will be accountable for the development, submission, and approval of an IDN Project Plan. As part of this Project Plan, in accordance with STC 28c, IDNs must identify 'Stage 1' process milestones for each project that will demonstrate progress against meeting project objectives during Years 2 and 3. Additional parameters and guidance related to these milestones will be reflected in the Project and Metrics Specification Guide and the IDN Project Plan template.

b. Stages 2 and 3: Project Utilization Milestones and System Transformation Utilization Milestones

The following project utilization and system transformation metrics will be used to measure IDN progress against meeting project goals and targeted levels of improvement against performance indicators. Section IV(c) of Attachment D goes into further detail on how these measures will be used to evaluate IDN performance.

Table 2. Project Metrics Menu

	Measure Name	Associated Projects	State-Wide Measure?
Workforce Capacity			
	Wait list in ED for inpatient BH admission	C1-4, D2, D4, D7, E7	x
	Wait times for intake and treatment for mental health	A1, D2, D4	
	Wait times for intake and treatment for SUD	A1	
	Expansion of workforce	A1	

	Measure Name	Associated Projects	State-Wide Measure?
Follow-up after ED visit or hospitalization			
	Follow-up after Emergency Department visit for alcohol and other drug dependence - within 30 days	A1, A2, B1, C1-2, D1, D6-8, E1-2, E7	
	Follow-up after Emergency Department visit for mental illness - within 30 days	A1, A2, B1, C1, D1-8, E2, E5, E7	
	Follow-up after hospitalization for mental illness – within 30 days	A1-2, B1, C1, D1-8, E1-2, E7	
	Follow-up after hospitalization for mental illness – within 7 days	A1-2, B1, C1, D1-8, E1-2, E7	
	Timely transmission of transition record (discharges from an inpatient facility to home/self-care or any other site of care)	A2, B1	
	EHR tracking of IOM social determinants	A2, B1	
Screening and Assessment			
	Percent of total population served who were assessed with appropriate standardized core assessment or screening tool(s) at appropriate intervals.	B1, D5, E4, E7	x
	Screening for clinical depression using standardized tool (whole population as indicated by assessment)	B1, D5, E3, E5, E6, E2	
	Screening for substance use including alcohol / SBIRT (whole population as indicated by assessment)	B1, D5, E3-4, E6, E7	
	Progress toward meeting criteria of B1 project (e.g. adoption of standardized assessment framework, universal screening, care management services, multi-disciplinary care teams, health promotion and self-management, full use of certified EHR, electronic care planning tools with information sharing capability etc.)	B1, E4	
Integration of Care			
	Progress along SAMHSA framework for Levels of Integrated Care	B1, E4	
	Integration of services addressing social determinants via selected community based organizations	A2, B1, C1-4, D2-3, D6, D8, E1-3, E7	
	Global score for selected general HEDIS measures for BH population (e.g., Diabetes Care)	B1, E1, E4, E7	
	Smoking and tobacco cessation counseling visit for tobacco users	B1, E1-2, E4, E7	
	Global score for USPSTF A & B recommendations for BH Population (e.g., cancer screening, aspirin, blood pressure, Hep B&C, intimate partner violence)	B1, E1-4, E7	
	Recommended well care visits for BH Population	A2, B1, E4	
	Smoking and tobacco cessation counseling visit for tobacco users	E1-2, E4 E7	
ED and Inpatient Utilization			
	Potentially preventable ED visits for BH population and total Population	A1-2, C4, B1, D1, D3-4, D5, 6, D8, E1-2, E6, E7	x
	Readmission to hospital for BH population for any cause at 30 days	B1, C1-4, E1, 4, 7	x
	Frequent BH ED visits for BH population	B1, D2, D4, D7, E6,	

	Measure Name	Associated Projects	State-Wide Measure?
		E7	

c. Stage 4 Alternative Payment Model Milestones

Pursuant to STC 44, the state must ensure IDNs participate in Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period. Table 3 identifies the APM milestones for meeting this demonstration objective.

Table 3. APM Milestones Menu

Alternative Payment Model (APM) Milestones
Engage in periodic meetings with Managed Care Organizations to support planning for transition to APMs
Conduct IDN baseline assessment of current use of APMs among partners
Participate in development of statewide APM roadmap
Develop IDN-specific roadmap for transition towards APMs

V. Requirements for IDN Project Plans

Once IDNs have been selected though the process described in the Program Funding and Mechanics Protocol (Attachment D), IDNs will prepare and submit Project Plans. Generally, the Project Plan will provide a blueprint of the work that an IDN intends to undertake, explain how its work responds to community-specific needs and furthers the objectives of the demonstration, and provide details on its composition and governance structure. In order to be eligible to receive IDN incentive payments, an IDN must have an approved IDN Project Plan.

The state will develop and post a draft IDN Project Plan Template for public comment by [6/1/16], and issue a final version by [8/1/16]. IDNs may use their capacity building and project design funds to prepare their Project Plans. As they develop their Project Plans, they must solicit and incorporate community input to ensure they reflect the specific needs of the regions they are serving. After the Project Plans are submitted to the state, they will be reviewed by an independent assessor, as described in the Attachment D, and may be subject to additional review by CMS.

Each IDN Project Plan must include the following:

1. *IDN Mental Health and Substance Use (MHSU) Needs Assessment:* Each IDN must conduct and report on a needs assessment that includes:

- A demographic profile of the Medicaid and general population living in the IDN Service Region, including by race, ethnicity, age, income, and education level
- Prevalence rates of MHSU disorders among both the general and the Medicaid population including rates of serious mental illness, substance use (alcohol, tobacco, opioids), and, to the extent possible, undiagnosed conditions.
- An assessment of the gaps in care for the target population and sub populations, (e.g., age groups, opiate users, those with co-occurring (MH/SU) disorders including the developmentally disabled)
- Identification of the current community mental health and substance use resources available for beneficiaries living in an IDN's region across the care continuum, including during recovery
- Identification of current community-based social services organizations and resources that could provide social supports to beneficiaries with behavioral health conditions, including housing, homeless services, legal services, financial help, nutritional assistance, and job training or other employment services

2. *IDN Community Engagement:* In developing its Project Plan, the IDN must demonstrate that it has solicited and incorporated input from individual members of the target population, the broader community and organizations that serve the community, particularly those who serve the Medicaid population and those individuals and populations with mental health and substance use disorders. The Plan must also describe the process the IDN will follow to engage the public and how such engagement will continue throughout the demonstration period.

3. *IDN Composition:* The IDN Project Plan will describe the membership composition of the network. IDNs must include a range of organizations that can participate in required and optional projects. Together, these partners must represent the full spectrum of care and related social services that might be needed by an individual with a mental health or substance use condition. Partners will include CMHCs, primary care providers , substance use providers including recovery services, peer supports, hospitals, home care providers, nursing homes and community based social support service providers. Please refer to the Program Funding and Mechanics Protocol (Attachment D) for additional detail on specific IDN composition requirements.

4. *IDN Governance:* The IDN Project Plan will describe how the IDN shall ensure that the governance processes established in the organizational structure of the IDN provide for full participation of IDN partners in decision-making processes and that the IDN partners, including the administrative lead, are accountable to each other, with clearly defined mechanisms to facilitate decision-making. Each IDN must have

an organizational structure that enables accountability for the following domains: financial governance and funds allocation, clinical governance, data/information technology, community engagement and workforce capacity.

5. *Financial governance and funds allocation:* The IDN Project Plan must describe how decisions about the distribution of funds will be made, the roles and responsibilities of each partner in funds distribution, and how the IDN will develop an annual fund allocation plan. The plan should also include a proposed budget that includes allocations for central services support, IT, clinical projects, and workforce capacity.

6. *Clinical governance:* The IDN Project Plan must describe how and by whom standard clinical pathways will be developed and a description of strategies for monitoring and managing patient outcomes.

7. *Data/Information Technology:* The IDN Project Plan must provide a data governance plan and a plan to provide needed technology and data sharing capacity among partners and reporting and monitoring processes in alignment with state guidance.

8. *Workforce capacity:* The IDN Project Plan must develop a plan aligned with the Statewide Workforce project goals to increase the numbers and types of providers needed to provide rapid access and integrated treatment in mental health and substance use programs, support services and primary care.

9. *IDN Project Selection:* The IDN Project Plan must describe its rationale for selecting from among the community driven projects. The plan must describe how these projects align with the transformation waiver objectives and how they will transform care delivery within the IDN. IDNs should select projects principally based on the findings from the MHSU Needs Assessment and should consider opportunities for rapid deployment among other factors.

10. *Implementation Timeline and Project Milestones:* The IDN Project Plan must provide a timeline for implementation and completion of each project, in alignment with state parameters. In addition, in accordance with STC 28c, the IDN must identify milestones for each project that will demonstrate progress against meeting project objectives. Additional parameters and guidance related to these milestones will be included in the IDN Project Plan template.

11. *Project Outcomes:* In accordance with STC 28e, the IDN Project Plan must describe outcomes it expects to achieve in each of the four project stages, in alignment with metrics and parameters provided by the state.

12. *IDN Assets and Barriers to Goal Achievement*: Each IDN Project Plan must describe the assets that =the IDN brings to its delivery transformation program, and the challenges or barriers the IDN expects to confront in improving outcomes and lowering costs of care for the target population. The Plan must also address how the IDN will mitigate the impact of these challenges and what new capabilities will be required to be successful.

VI. Process for IDN Project Plan Modification

No more than once a year, IDNs may submit proposed modifications to an approved IDN Project Plan for state and CMS review. In certain extremely limited cases it may become evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments require the IDN to modify its original plan. As part of the Plan modification process, an IDN may seek to "reclaim" incentive funding that is unearned because unique circumstances led to the IDN's failure to achieve certain performance metrics for a given reporting period. As described in Section VII of Attachment D, funding amounts that are unearned will be available to the IDN for two immediate, subsequent reporting periods. Project Plan modifications may not decrease the scope of a project unless they also propose to decrease the project group's valuation, nor can they lower expectations for performance because it has proven more difficult than expected to meet a milestone.